DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Rural Health Clinics
Managed Care Plans
CSO Administrators
Regional Administrators

Memorandum No: 03-70 MAA
Issued: September 23, 2003

For Information Call:
(360) 725-1840

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

Subject: Discontinued State-Unique Procedure Codes Used in the Rural Health Clinic Program

Effective for dates of service on and after October 1, 2003, the Medical Assistance Administration (MAA) will **discontinue** all state-unique procedure codes previously used in the Rural Health Clinic (RHC) Program.

Coding Changes

The Health Insurance Portability and Accountability Act (HIPAA) requires all healthcare payers to process and pay electronic claims using a standardized set of procedure codes. In order to comply with HIPAA requirements, MAA is **discontinuing all state-unique procedure codes** and will require the use of applicable CPT™ and HCPCS procedure codes.

Current MAA Billing Process for Rural Health Clinics

MAA currently requires a clinic-specific state-unique procedure code to describe services provided in Rural Health Clinics (RHC). The RHC bills MAA for all covered RHC-services using a specified provider number with a specified state-unique code. The RHC is reimbursed at a set encounter rate.

Effective for claims with dates of service on and after October 1, 2003, **MAA is discontinuing each clinic's state-unique encounter code**.

New Encounter Code for Billing RHC Services

In order to ensure a HIPAA-compliant billing system using standardized coding, RHCs will bill MAA using the **HCPCS code T1015**. The **charge** for HCPCS code T1015 **is the clinic's encounter rate.**

T1015: Clinic visit/encounter, all-inclusive

For dates of service prior to October 1, 2003, continue to bill RHC encounters using your RHC provider number and clinic-specific encounter code. For dates of service on and after October 1, 2003, you must bill using the new encounter code.

Billing for Delivery Case Rate Enhancements for Managed Care Clients

When an eligible pregnant woman who is assigned to an MAA managed care plan delivers, MAA makes a supplemental Delivery Case Rate (DCR) enhancement payment directly to the RHC. **The RHC (or the managed care plan on behalf of the RHC) may bill MAA for the DCR enhancement only when the RHC's provider actually does the delivery**. Do not bill MAA for the DCR enhancement if another provider performed the delivery. However, MAA will pay the RHC the DCR enhancement if the RHC bears full financial risk for deliveries done by other providers through its contract arrangements with the managed care plan.

Bill MAA for the DCR enhancement using either **delivery-only code 59409 or 59514 with modifier UC**. Modifier UC is a payer-defined modifier. MAA defines modifier UC as "FQHC/RHC Service." Use the ICD-9 diagnosis code V68.9 (unspecified administrative purposes).

Billing for BH+ Maternity Supplements

When an eligible pregnant woman who is enrolled in Basic Health Plus (BH+) and is on the "S" Pregnancy program, delivers, MAA makes a supplemental enhancement payment (referred to as an "S-Kicker" enhancement) directly to the RHC. **The RHC (or the managed care plan on behalf of the RHC) may bill MAA for the S-Kicker enhancement only when the provider or contracted provider actually does the delivery**. Do not bill MAA for the S-Kicker enhancement if another provider performs the delivery. However, MAA will pay the RHC the S-Kicker enhancement if the RHC bears full financial risk for deliveries done by other providers through its contract arrangements with the Healthy Options plan.

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Bill MAA for the S-Kicker enhancement using **unlisted maternity care and delivery code 59899 with modifier UC**. Modifier UC is a payer-defined modifier. For MAA, UC is defined as "FQHC/RHC Service." Use the ICD-9 diagnosis code V68.9 (unspecified administrative purposes).

For more information regarding RHC billing and reimbursement, contact Mary Wendt, RHC Program Manager, by email at wendtma@dshs.wa.gov, or by phone at (360) 725-1840.

MAA is currently updating the Rural Health Clinic Billing Instructions. Attached are replacement pages 3/4 and 15/16 for MAA's Rural Health Clinic Billing Instructions, dated July 2001, reflecting HIPAA implementation.

To obtain this document electronically, go to MAA's website at http://maa.dshs.wa.gov (click on the Provider Publications/Fee Schedules link).

CPT codes and descriptions are copyright 2002 American Medical Association.

Provider Number – A seven-digit identification number issued to service providers who have signed the appropriate contract(s) with MAA.

Remittance And Status Report (RA) - A report produced by MAA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Rural Area – An area that is not delineated as an urbanized area by the Bureau of the Census.

Rural Health Clinic (RHC) – A clinic that is located in a rural area designed as a *shortage area* (CFR 42, Chapter IV, 491.2). A rural health clinic will be certified for participation in Medicare in accordance with subpart S of 42 CFR, part 405 (CFR IV, 491.3) as a hospital-based or freestanding facility.

Shortage Area – A defined geographic area designated by the Department of Health as having either a shortage of personal health services [under Section 1302(7) of the Public Health Service Act] or a shortage of primary medical care manpower [under Section 332 of that act].

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. [WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
[WAC 388-500-0005]

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

Rural Health Clinics

What is a Rural Health Clinic?

A rural health clinic (RHC) is either a hospital-based or freestanding facility certified under Code of Federal Regulations (CFR), title 42, part 491. A rural health clinic is located in a rural area designated as a shortage area.

Those providers interested in applying as either one of the two types of RHCs should contact Medicare for criteria and qualifications.

How does MAA reimburse for services in a rural health clinic?

Encounter Code: Use HCPCS procedure code T1015, Clinic visit/encounter to bill. All services must be billed to MAA on a HCFA-1500 claim form.

Encounter Rate: MAA pays only for primary care services provided by Medicare-certified RHCs on an **encounter rate** basis, rather than on a fee-for-service basis. The encounter rate for each rural health clinic is established by the RHC Program Manager based on the clinic's Medicare Cost Report. **Refer to Medicare's Rural Health Clinic Guide for covered RHC services.**

Note: Both hospital-based and freestanding RHCs must bill MAA for RHC-covered services using HCPCS procedure code T1015 and its encounter rate. No other procedure codes or usual and customary fees may be used.

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payer of last resort.

11a. **Insured's Date of Birth**: When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being resubmitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form. You must total each page separately.**

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using a 6-digit or 8-digit date of service. (Example: October 4, 2003 = 100403 or 10042003)

Do not use slashes, dashes or hyphens to separate month, day year.

24B. **Place of Service**: Required. Enter a **11** for the Place of Service.

24C. **Type of Service**: Not Required.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter procedure code T1015.

24E. **Diagnosis Code**: Required. Enter the appropriate ICD-9-CM diagnosis code.

24F. **$ Charges**: Required. **Enter your encounter rate for the service performed.** Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. Enter the correct number of units. Use only whole numbers, not fractions.

25. **Federal Tax ID Number: Leave this field blank.**

26. **Your Patient's Account No**.: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the total amount of billed charges. Do not use a dollar sign or decimal point.

29. **Amount Paid**: If you receive an insurance payment or client paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use a dollar sign or decimal point or put Medicare payment here.

30. **Balance Due**: Required. Enter dollar amount owing (equal to field 28 value minus field 29 value). Do not use a dollar sign or decimal point.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Put your *Name, Address,* and *Telephone #* on all claim forms.

GRP#: **Enter the DSHS provider number assigned to you by MAA.**